

FILED DEC 27 1950

STANDARD CERTIFICATE OF DEATH

State File No. 40457

BIRTH NO. _____		REG. DIST. NO. 133		PRIMARY REG. DIST. NO. 3022		Registrar's No. 99			
1. PLACE OF DEATH a. COUNTY Harrison				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Davies					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bethany Hospital		c. LENGTH OF STAY (In this place) 1 mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Coffey		031" 1			
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethany Hospital + Clinic				d. STREET ADDRESS none					
3. NAME OF DECEASED (Type or Print) John Parker Bales		a. (First)		b. (Middle)		c. (Last)			
4. DATE OF DEATH 12 17 1950		(Month)		(Day)		(Year)			
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH March 2, 1877			
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Livingston, Ky.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Daniel Boone Bales		13b. MOTHER'S MAIDEN NAME Mary (unknown)		14. NAME OF HUSBAND OR WIFE Ida W. Bales			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Ida W. Bales Coffey					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 5 yrs - 8 yrs - 42 21	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 9-15, 1950, to 12-17, 1950, that I last saw the deceased alive on 12-17, 1950, and that death occurred at 4:00 P.M. from the causes and on the date stated above.									
23a. SIGNATURE W. F. Boyle M.D.		(Degree or title)		23b. ADDRESS Bethany Missouri		23c. DATE SIGNED 12-18-50			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-17-50		24c. NAME OF CEMETERY OR CREMATORY St. Joseph's Mont.		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.			
DATE REC'D BY LOCAL REG. 12-18-50		REGISTRAR'S SIGNATURE Zola Burres		25. FUNERAL DIRECTOR'S SIGNATURE M. J. Bales		ADDRESS Bethany Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



FEB 15 1951

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3899

P. O. Address Bethany Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.